

1979

Some observations of the Swedish psychiatric system

Gunnar Robert Almgren
Portland State University

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SOME OBSERVATIONS OF THE SWEDISH PSYCHIATRIC SYSTEM

by

GUNNAR ROBERT ALMGREN

A report submitted in partial fulfillment of the
requirements for the degree of

MASTER OF
SOCIAL WORK

Portland State University
1979

Approved



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CHAPTER I

INTRODUCTION

The purpose of this report is to introduce the reader to the system of psychiatric services in Sweden. The format of this report is a brief summary of the economic, political and value context of the Swedish welfare state, a review of the essential services available to the Swedish citizen under present Swedish social welfare policy, and then an overview of Sweden's psychiatric system. The overview of the system itself includes a discussion of general characteristics as well as an examination of the system as it operates in one particular region.

The facts, observations and opinions making up this report are based upon my visits to Swedish social psychiatric facilities and interviews with Swedish psychiatric professionals during the summer of 1978, and a review of both Swedish and American literature on the topic of the Swedish psychiatric system. The writing of Fliesher, F. (1967), Fliesher, W. (1956), Furman (1966), and Vail (1968) were particularly helpful in outlining the Swedish Medical Health System. Berggren, Rooth and Szasody (1963) and Godman (1963) contributed to the understanding of innovations in Swedish psychotherapy. A document published by the

Stockholm County Council (1974) outlining the organizational structure of the psychiatric system in the greater Stockholm region was an excellent source for an understanding of the system as it is organized and operated on the local level.

This report is not a comprehensive overview of the Swedish Psychiatric System, nor does it attempt to discuss in depth the major characteristics of Swedish psychiatry that would be necessary in a more scholarly document. The majority of the material is subjective in nature and reflects primarily the observations of practitioners in the psychiatric field rather than trained researchers. Nevertheless it does introduce the reader to the essential organization, structure and services of the Swedish Psychiatric System.

There is an important relevance of this subject to social work as it is practiced in the United States because, as Tomasson (1970) observes, Sweden may be the prototype of the future United States welfare state. Comprehensive social welfare planning remains a goal of the United States social work profession and Sweden provides an example we can learn from. The present Swedish psychiatric system itself is the result of an ongoing comprehensive healthcare planning process that I believe has some intriguing possibilities for the United States. If the social work profession in the United States is to realize its goal of comprehensive planning the knowledge of other societies engaged in this process must be shared and observed.

The introduction of this report will now proceed to a discussion of the essential characteristics of the Swedish welfare state.

THE ECONOMY

Kenneth Boulding asserts that social policy can be identified as that "integrative system" by which a society causes a unilateral transfer of (goods and services) on the basis of legitimacy, identity or community integration. Boulding's definition of social policy is in response to the obvious; that is it is difficult to distinguish when social policy begins and other national policies (particularly economic policy) end. In examining the development of Sweden's welfare state the fragile distinctions disappear. Therefore, in order that even a brief review of Sweden's social policy be adequate it must be outlined in terms of the characteristics of contemporary Sweden's economy.

Childs (1936) describes Sweden's economic system as a balance between outright socialism and unfettered capitalism. The government's fundamental economic commitment is to full employment, and the equitable distribution of income and minimum standard of living to all its citizens. Schmitzer (1970), observed that the Swedish government exerts its influence in five ways:

- 1) by the utilization of a 5 year economic forecast by which private and government capital expenditures are influenced
- 2) by its purchases of goods and services adding directly to the demand for output and

availability of income to persons and business firms and 3) expenditures for income maintenance, and the battery of basic services which are essential to the "cradle to grave" universal social security concept, 4) rigid mechanisms for tax collection which themselves limit accumulation of material assets and capital expenditures and 5) by public investment or outright ownership of services, industries, and resources that make up a vital component of the economic system.

Schmitzer (1970) further observes that, although the private sector is dominant in terms of consumption and output, the influence of the public sector is decisive.

Taken as a whole, the economic system has allowed the second highest standard of living in the world with the least economic disparity among Sweden's citizens. If one were to include the universal availability of a number of basic services it could be argued that Sweden has attained the highest standard of living.

THE POLITICAL SYSTEM

Tomasson (1970) observed that the modern history of Sweden is characterized by institutional stability, continuity, and a lack of severe domestic strife. This is due in no small part to the early development of constitutionalism, dating back to the death of Charles XII in 1718. The bloodless constitutional revolution gave henceforth undisputed pre-eminence to the Riksdag, Swedish Parliament (Nagel Publishers, 1973).

Since 1971 Sweden has been governed by a unicameral 350 seat Riksdag whose term of office are for three years.

Election is based upon proportional representation among the four dominant political parties, the Conservative, Center, Liberal and Social Democrat. All citizens (save those placed under legal guardianship) who have reached their 20th birthday have a right to vote. Because there are no regulations governing the nomination of candidates at general elections, the "official" ballots distributed by the principal political parties eliminate independent candidates.

The Riksdag, with its four main political parties is the central instrument governing Sweden, with local control limited to means by which to carry out broader government policy. All laws, taxes issues, and budgetary considerations go through a process of rigorous, scholarly investigation by a committee of inquiry whose job it is to frame a recommendation comparably free of lobbying compared with the U.S. Par-Erik Back, Professor of Political Science at Umea University observes that "the finest legal scholarship in Sweden goes into the writing of committee reports" (Back 1967). Prior to being introduced to the Riksdag these reports are circulated among the authorities, institutions, individuals and private organizations concerned. There a system of scholarship and feedback are well integrated into the legislation process with positive benefits in terms of rational policy decision making.

A look at the characteristics of Sweden's four principal political parties is illuminating to an understanding

of the values which underly Swedish social policy. As Par-Erik Back (1967) observes "Channeling the opinions of citizens is only one of a party's functions. By shaping the minds of a politically conscious and initiated elite, it also exerts a long-range influence on the opinions and attitudes of the 'man in the street.' " The positions of the main parties as epitomized by Back (1967) are as follows:

Conservative Party	Sanctity of Private Property, individual liberty, political democracy. Supportive of welfare but opposed to state paternalism and heavy taxation.
Center Party	Originally represented the interests of the small farmer, presently appeals to common man concerns over technological advance, taxation, support of small businesses, and private ownership of farmland and forest.
Liberal Party	Represents diverse groups of free thinkers, minority interests, Keynesian economic thought, and social responsibility.
Social Democrats	Early seeds in Marxism, its contemporary labor based platform adheres strongly to progressive democracy in economic policy: full employment and commitment to universal welfare.
Communist Party	Originally hardline Marxist and pro-Soviet, it is now independent of the international communists and endorses parliamentary

democracy. Although a negligible influence, it reenforces tendencies toward parliamentary socialism.

In the 1975 general elections the electorate abandoned their support of the Social Democrats in favor of a more conservative coalition of the Conservative, Center, and Liberal parties. Although the policies of the Social Democrats have not been abandoned nor the schemes in the Swedish welfare state rejected, it does signal a reassessment of the aggressive universal welfare policies of the past forty years.

In summation, the salient features of the political system which appear to support the present social policy commitments are: 1) a highly centralized government which reenforces a consistent and universal welfare model, 2) a recognition among all dominant political parties of social welfare concerns in their platforms and 3) a legislative process that allows for the scholarly evaluation of policies before the political evaluation commences.

FUNDAMENTAL VALUE ORIENTATIONS

In evaluating components of social policy, a superior understanding necessitates a review of fundamental value orientation. Underlying a conglomerate social policy that is rational, consistent, and universal and four value orientations that pervade the contemporary Swedish culture;

Empiricism, Egalitarianism, Legalism and the Malleability of Institutions. Tomasson (1970) in his examinations of contemporary Swedish society asserts these values to be fundamental themes characterized in Swedish behavior and institutions. Their representation in social policy decisions was observed by the author.

Empiricism forces the rational, factual investigation and careful evaluation as part of the decision making process. Empiricism is best represented by the "committees of inquiry" utilized to weigh the facts, issues and effects of policy prior to the assault of the political interest process so pervasive in the American legislative institution.

Egalitarianism reveals itself in an economic system that reinforces material equality on the same priority as social equality.

The Swedish reliance on legalism or "procedurism" supports a comprehensive, organizational system that aside from being rational, is a model of consistency. Later evaluation of the Northeastern Psychiatric District will substantiate this observation.

Finally, the Swedish belief that institutions can and should be structured to accomplish agreed-upon ends challenge the resistances to change that are a characteristic of social institutions. Tomasson (1970) citing several examples of the ability of Swedish social institutions to change refers to the recent radical restructuring of the school sys-

tem, recent radical solutions proposed for changing the relations between church and state, and of course the challenge to the institution of marriage that has taken root in contemporary Sweden. Underscoring institutional malleability is the emphasis it bears on social institutions to respond to innovation, and the dominance of outcome over symbolism.

CHARACTERISTICS OF SOCIAL WELFARE POLICY

The concept of social policy to the Swedish is summed up by a quotation from a former director general of the National Social Welfare Board for more than twenty years, Ernst Bexelius.

Sweden's social policy has nothing at all to do with Marxism or Socialism. It is quite simply a system that aims at preventing unexpected illnesses, disability, and old age from destroying a person's life . . . Like economic and educational policy, social policy contributes to a leveling out.

Bexelius' quote is a representative one not only because of his position; he also represents well the Swedish emphasis on the pragmatic.

In evaluating the development of Swedish social welfare policy it is important to recognize at the outset its three areas of primary emphasis: 1) The guarantee to every Swedish citizen of a simple and decent standard of living despite age, disability, or lack of a provider. Benefits that support a standard of living consistent with the entire population. 2) Collective and equitable distribution of

responsibility for social welfare expenditures among the entire population. 3) Social welfare to be the right of every Swedish citizen, irrespective of financial status.

In contrast to the United States, where poverty rather than affluence has been traditionally regarded as a matter of individual choice, poverty in Sweden has been a common cultural experience. Nineteenth century poet C.J.L. Almqvist wrote "In Sweden there is no question of seeking poverty. It is a dowry from nature . . ." (Jenkins, 1968). Although changes in terms of industrialization were taking place throughout the 19th century the economy was essentially a static one until approximately 1890. Meanwhile, birthrates, population, and poverty were on the rise, leading to massive emigration. A simple but eloquent statement from one emigrant is illustrative: "Mother Sweden can be compared to a mother who has too many children: she is too poor to feed and clothe them" (Jenkins, 1968). Because poverty in Sweden was for many decades a widespread cultural experience it is not astounding that social welfare in Sweden is itself a universal concept.

Tracing briefly the development of a universal social welfare policy, it begins with the founding of the Swedish Social Democratic Party in 1889. Although only seven percent of the population had voting rights upon its founding, its roots in the powerful Swedish Labor movement and later in universal suffrage propelled the Social Democrats from one

parliamentary seat in 1897 to 64 in 1911 (Jenkins 1968). By 1918 social reform measures involving industrial safety, unemployment, old age pensions and home loans to the low-income were passed and the Social Democrats were the most powerful force in the Swedish Parliament. The Social Democrats came into power in 1933 after several years of social unrest, political instability and the re-emergence of an employment crisis. This began the Social Democrats' unprecedented forty year control of the Swedish parliament and the established commitment to universal social welfare.

The Social Democrats faced two crises in 1933, an unemployment rate of forty percent and low birthrate. In response, the first policies of the new government undertook public work projects (with standard industry work wages), a package of subsidies to expectant families including free comprehensive medical care, and a cash benefit payment at birth and legal protection from loss of employment due to pregnancy that guaranteed maternity leave. In 1946 the old age pension system was revised to keep the aged above poverty level as a permanent feature; universal free student lunches, and financial assistance to students were begun. In 1948 a universal cash subsidy was established for each child. By 1959 a statutory universal three week vacation, compulsory national health insurance and enlarged pension benefits completed the major features of the Swedish Social Welfare program and its universal "womb to tomb" security concept (Jenkins 1968).

The main social welfare benefits as of this time are as follows:

Child Welfare

A child allowance of approximately \$450.00 per year is paid for all children under the age of sixteen. Children between the ages of sixteen and eighteen and under the custody of one parent are guaranteed a general maintenance subsidy of approximately \$800.00.

Children requiring supervision due to employment of parents are eligible for admittance to a day nursery whose cost is based upon parental income. The administration of these nurseries and after school centers are by municipality, with central government financial support. An expansion program is under way designed to provide places for 225,000 children by 1980.

Education

Nine years of comprehensive schooling from age seven is required, and there is an optional two year secondary school (gymnasium). Although universities and colleges are free of charge along with a variety of study assistance benefits, there is great competition for admission to universities.

Housing

Housing allowances are available to low income families with an additional 900 kroner (\$250) per year per child

benefit. All housing allowances are related to family income. In 1976, there were 570,000 families receiving some form of housing allowance. Pensioners receive a municipal housing allowance if they have no appreciable income in excess of the basic pension. In addition, government loans account for approximately ninety percent of the new dwelling construction, based on 1974 figures of the Ministry of Finance.

Healthcare

A comprehensive health insurance package covers the entire population. In the event of illness there is a monthly benefit payment which amounts to ninety percent of earned income, is taxable, and counts towards the calculation of pension benefits.

All medical fees in excess of four dollars are paid, except in cases where a person sees a physician not employed by the public health service. In such cases the patient pays approximately \$8.50 at a maximum. Travelling expenses connected with illness and medicare are paid for beyond a \$5.00 expense. Dental expenses are allowed up to a fifty percent subsidy.

Maternity benefits include a \$4.50 per day support payment for seven months during the pregnancy and birth period and those eligible for illness benefits for wage earners (ninety percent of gross income) are given the higher of the two benefits.

Parents who have to be absent from work to care for a sick child are entitled to full pay benefits for a maximum of ten days per year.

Old Age

Besides comprehensive medical care and housing subsidies, there is a pension system which is based upon the earning of the pensioner (80 percent of the annual earned income average based upon the individual's highest fifteen year income) which begins at age sixty-five. A partial retirement option is available for those between the ages of sixty and seventy requiring at least half-time employment in exchange for 80-85 percent of earlier earned income.

According to the 1976 Swedish Budget Summary the average pension benefit was approximately \$5,000 cash per year for two married pensioners.

Unemployment

Unemployment benefits, though universal since 1974, vary according to the person's salary, occupation and union affiliation. The guaranteed benefit is approximately \$10.00 per day, although most benefits paid out exceed this.

To this point I have been reviewing only the basic social security provisions. In addition to these basic provisions there is a lengthy list of benefits to the citizens of Sweden that can be considered a part of the Swedish

social welfare institution. These benefits include an excellent system of public transportation, subsidized recreation, and innovative criminal rehabilitation to name just a few. A comprehensive review of Swedish social welfare is beyond the scope of this report.

Although this review of Swedish social welfare characteristics has been brief, it indicates the commitment to universal social security. Against this backdrop we may now evaluate Swedish social policy toward a particular segment of the population, the mentally disabled.

CHAPTER II

THE NATIONAL PSYCHIATRIC SYSTEM: GENERAL CHARACTERISTICS

Until mid 1960 the bulk of Swedish mental health services were carried out through centralized state mental hospitals, approximately twenty-five in number giving care to 30,000 patients (Furman 1966). The process of de-institutionalization in Sweden has radically restructured the mental health system. Presently, the responsibility for the operation of all but the largest of these facilities has been given to regional administrative districts. Sweden's three largest cities, Stockholm, Goteborg and Malmo, are self-contained districts. There are twenty districts in Sweden giving regional health services. The present system places the administration of psychiatric services within the general framework of regional health care districts. This is in contrast to the United States pattern where mental health services tend to be administrated apart from other health care services.

The following diagrams are simplified versions of the revision that took place in 1967.

The older (prior to 1967) organization of psychiatric services is shown in Figure 1 on page 17, and the reorganization of 1967 in Figure 2, page 18. Both of these figures

Mental Illness

Mental Retardation

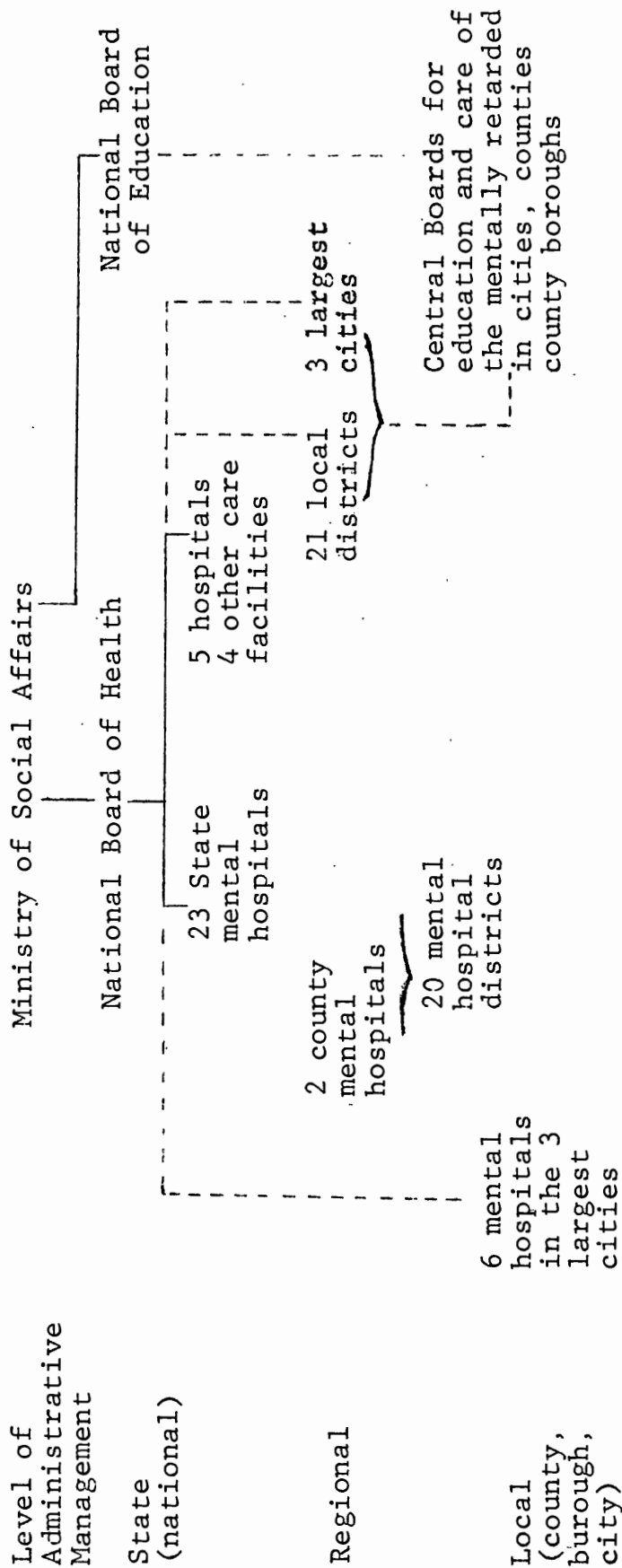


Figure 1. Sweden: Organization chart of mental illness and mental retardation. (Simplified Diagram)

Source: David Vail, Mental Health Systems in Scandinavia, copyright 1968, Springfield, Illinois.

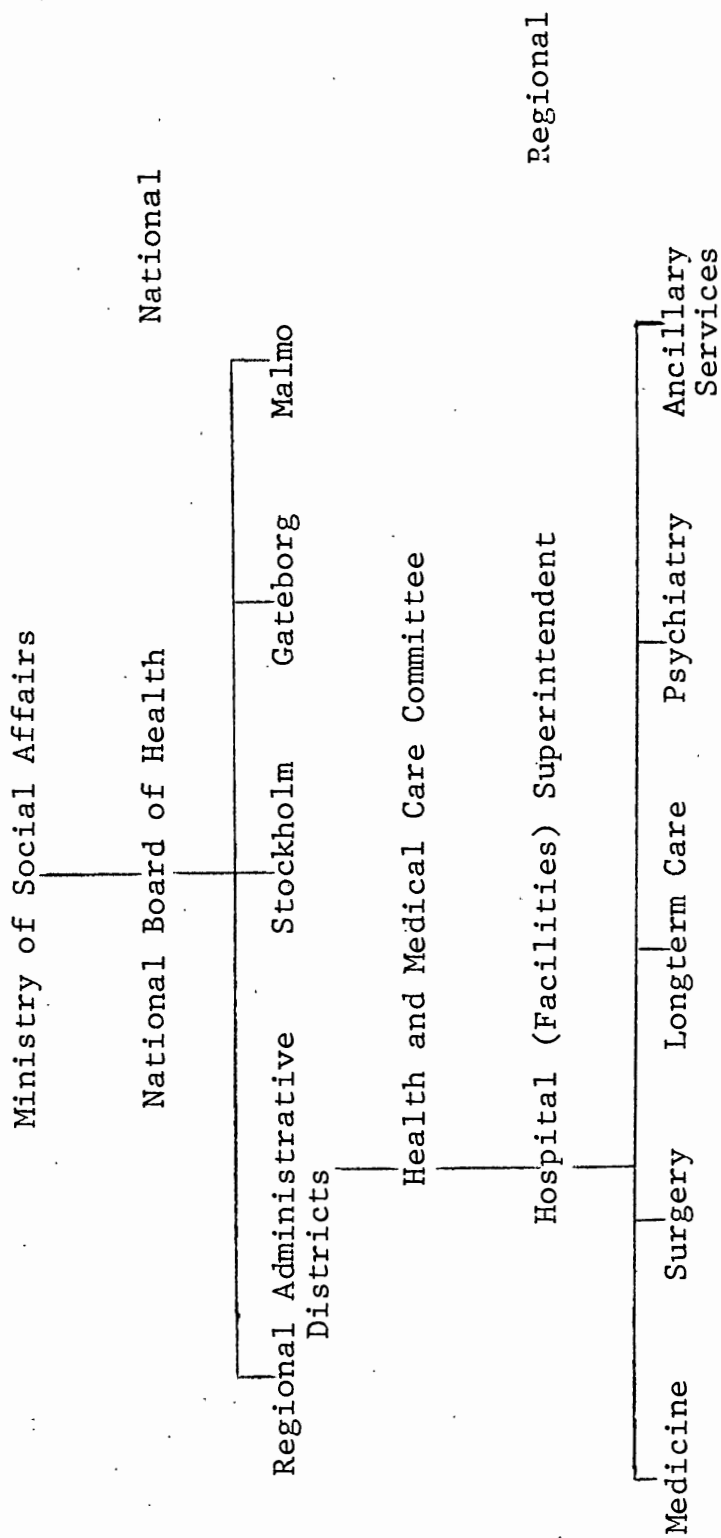


Figure 2. Organization chart of mental illness and mental retardation in Sweden after 1967.

Source: Psykiatriblocket: Nord Östra Förvaltnings Området, 1974, Stockholm City Council.

are in simplified form.

Vail (1968) reports that according to 1967 statistics there were approximately 27 thousand psychiatric beds of which approximately 21 thousand were located in regional state run hospitals averaging around 900 beds. The availability of hospital beds, again according to 1963 figures, was 3.57 beds per 1,000 population. This availability was based upon a utilization estimate of 3.48 beds eliminating the overcrowding crisis that had occurred in the mid 1950's. These statistics indicate that, prior to the reorganization of 1967, that approximately eight out of ten hospitalized psychiatric patients were cared for in large state hospitals. Presently, the majority of patients are being treated in smaller acute care hospital psychiatric units although the utilization pattern remains essentially the same at 3.5 psychiatric beds per 1,000 persons. However, like in the United States the average length of stay for a hospitalized psychiatric patient has been reduced from years to a few weeks.

Expenditures in psychiatric services in the 1977/78 fiscal year were estimated to be approximately 2.3 billion kroner (approximately 550 hundred million dollars) out of a total welfare budget of 30 billion kroner (7.3 billion dollars). The mental health expenditure refers only to clinical and rehabilitation services and not monetary allowances.

CLASSIFICATION OF MENTAL DISORDERS

Sweden, like the other Scandinavian countries, is very much vested along the lines of a strict medical model -- much more strict than the American version of the medical model in that it attributes mental disorders to a disease process rather than a psychosocial product.

The American model tends to place more emphasis on external psychosocial processes as the causal link. As Vail (1968) observed there is less emphasis in Scandinavian psychiatry on mental disorder as a maladaptive process and more emphasis on heredity and constitution. Put more simply, in America a mentally ill person is the product of a complex psychosocial process. In Scandinavia mental disease is just something that happens to a person. My own observations are that this concept of mental illness has given the Swedish model more emphasis on social and medicinal therapy and less emphasis on causal oriented psychotherapy. Empirically, this can be seen in relatively low numbers of psychologists in the Swedish mental health system as compared to psychiatrists, nurses and social workers. For example, in the Northeast Psychiatric District evaluated in this report there were 6.5 psychologists compared with approximately 30 social work positions.

Other than the different concept applied to the term mental illness, the classification of mental disorders is

according to the same International Classification system adaptable in terminology to the American Psychiatric Association index. However, Vail (1968) compared first admissions in Minnesota to those in Sweden and found that while psychotics accounted for 31 percent of the first admissions to mental hospitals in Minnesota and psycho-neuroses accounted for only 18.4 percent, in Sweden the neurotic disorders accounted for 45 percent of first admissions and the psychotic disorders approximately 12 percent or less. The implication is either that the incidence of psychoses in Sweden may be less than half that of Minnesota or that Swedish psychiatrists are much less inclined to interpret behavior as psychotic.

PSYCHIATRIC HOSPITALIZATION PROCEDURES

Unlike the United States where there has been heavy emphasis on civil due process procedures outside the authority of hospitals in recent years, Sweden continues to rely upon the physician as the chief authority in determining the need for hospitalization. The grounds for a physician's decision to hospitalize an individual are based upon the physician's judgement that the person would endanger himself or someone else if released. By Sweden's commitment standards "need for treatment" is not utilized as a criterion, rather, commitment is based upon behavioral consequences. As in the United States most patients are treated on a voluntary basis; i.e., with consent free of objection.

All hospitalized psychiatric patients are under what is termed "Paragraph 55." According to Vail (1968) this regulation gives the treating physician the authority to detain a voluntary patient who expresses a desire to leave pending the initiation of formal commitment procedures. This provision is utilized for patients who in the judgement of the medical staff, may endanger themselves or someone else if discharged.

Besides "Paragraph 55" there are two formal commitment procedures, one voluntary and the other involuntary.

The voluntary procedure involves the patient's signature of a formal consent form which must be witnessed by two people, excluding the treating physician. The signing of this document gives the physician complete authority to keep the patient until, in the physician's judgement, the patient is ready for discharge. Under this provision the physician may also direct the patient to adhere to a conditional discharge. Should the patient object to hospitalization after signing this consent there is no further formal procedure of appeal, under the sign consent type of commitment the protection of "Paragraph 55" allowing a formal hearing before a hospital board would not apply.

One involuntary commitment procedure consists of a formal certification by a physician authorizing immediate hospitalization and subsequent hearing before a hospital commitment board consisting of a physician, a prominent member of the community and one attorney. The initial

commitment is for two weeks, after which there is a second hearing before this board which can certify continued commitment, conditional discharge, or complete discharge. Individuals under formal commitment or conditional discharge have a board hearing every six months. Although all physicians have the authority to authorize psychiatric hospitalizations, in practice the number having admitting privileges to psychiatric hospitals and/or having the authority to sit on certification boards is limited.

Another form of involuntary commitment applies to some mentally ill offenders. The Mentally Ill Offender hospitals have patients committed under the mentally ill offender rule, which dates back to 1929. While this law is the corollary to the McNaghten rule in the United States, it is different in terms of its criteria for culpability. Under the McNaghten rule, the mentally ill offender must be shown by a preponderance of evidence to be so impaired by his illness that he is incapable of distinguishing right from wrong. Under Swedish law, those offenders impaired by psychoses "or another mental abnormality of so profound a nature, as to be regarded as equal to a psychosis" may not be punished under the correction system. Therefore the Swedish law presumes the inculpability of the seriously mentally ill offender.

A second major distinction of Swedish forensic psychiatry apart from the United States model lies in the competence and responsibilities of the examining psychiatrist.

The forensic psychiatrist in Sweden undergoes, in addition to regular psychiatric training, specific training in criminology, law, and genetics. Further, the forensic psychiatrist avoids much of the problem of siding with either the prosecution or defense by giving testimony relevant only to diagnosis.

A final involuntary treatment provision is that which is applicable to alcoholics. Approximately 16 percent of admissions to Swedish psychiatric hospitals are under the diagnosis of alcoholism (Vail 1968) of which many are committed by municipal or county "temperance boards." These boards have traditionally been made up of prominent citizens appointed by municipal/county administration (Garansson 1938). Recognizing the problem with alcoholism at the turn of the century the Riksdag established local temperance boards whose function in part was to deal with the problem drinker. These boards have retained their authority to commit the habitual alcohol abuser to involuntary treatment should that individual's conduct become a threat to himself or the community. Many hospitals have alcohol treatment wards, and this form of treatment has been made readily accessible everywhere.

PROGRAM TYPES AND CHARACTERISTICS

In-patient

Magnussen (1963) identifies the stages a patient goes through in the Danish psychiatric model and the services

at each stage. Although there are differences between the Danish and Swedish service models in terms of general organization, the services rendered the patient are similar.

In the first stage, the patient is referred for hospitalization from his home community, usually by a local physician, family, or specialists in the community familiar with the patient. During this stage, attempts are made to treat the patient on an out-patient basis if at all reasonable. Treatment in this instance is administered at the local social psychiatric clinic (comparable to our mental health center). Those patients requiring hospitalization are referred to a psychiatrist having admission privileges to the regional psychiatric in-patient facility. In the Swedish model this is intended to be the same psychiatrist having responsibility for services at the patient's community social psychiatric clinic.

During the second stage, hospitalization, emphasis is placed upon identifying the patient's sources of strengths and stress through collaboration with the patient's family, close friends, employer, and physician (if any). These efforts are carried out by a social worker. The Swedish model, because it shares staff with the community social psychiatric clinic is able in many cases to facilitate this process by having the same social worker assigned to in-patient and out-patient functions with the patient. During this stage the patient is (unless grossly out of control) given occupational therapy by a trained activity therapist.

Magnussen (1963) states that the role of the occupational therapist during this period of treatment is to give the patient diversion from his symptoms. Medical treatments utilized during hospitalization include electroconvulsive therapy, psycho-pharmacology, and supportive individual medical psychotherapy (nurse and psychiatrist). In addition the patient's personal appearance is attended to and progression into the community of the ward. As soon as the patient reaches a point when able to be drawn into the ward community, "physiotherapy" commences which emphasizes rehabilitation through physical movement and cooperation with other patients. Included are relaxation treatments, physical games (volleyball, badminton), folk-dancing, and singing games. Some larger facilities include a music therapist and librarian. At Dandryds Hospital, in-patients had access to a very large, well equipped wood working shop which was also used by out-patients.

The third stage in the process is when the patient is ready for discharge. The Swedish model uses four types of discharge status, day hospital, night hospital, home furlough and complete discharge. Like the United States model, these concepts are used for gradual re-integration into the community. However, the Swedish mental health system appears to place much emphasis on the "dagvard" (day ward) model in even acute care hospitals while the concept of partial hospitalization seems to be limited to state hospitals in the United States.

Berggren, Rooth, and Szusody (1963) identify some advantages of the Swedish Day Care model which are: disruption of that rigid hospital hierarchy which places the patient in an extremely dependent role, more economic use of resources in staff and facilities, and provision of a model of society with realistic demands and gratifications and variety of functions and personal relationships.

Ideally, the day ward assumes the essential characteristics of a place of work where working hours are passed and one is expected to perform tasks. While Berggren, Rooth and Szusody wrote of this concept in 1963 they were referring to a single innovative 35 patient program in South Hospital, Stockholm. The district described in this paper presently has a 22 patient ward at Dandryds modeled after the program described by Berggren, Rooth and Szusody.

Out-patient

Out-patient services rendered to psychiatric patients, like those in the United States, differ tremendously, dependent upon the theoretical base of the clinician dispensing the services. As in the United States, services include medication management, activity therapy, casework services and various psychotherapy.

Throughout conversations with Swedish mental health professionals there was the consistent observation that (at least presently) the United States is looked upon as the chief source for the latest techniques in psychotherapy.

As in the United States, the Swedish mental health professionals tended to be rather independent when choosing their theoretical basis and psychotherapeutic approach. In other words, there did not seem to be a definite national approach to human psychosocial organization and psychotherapy any more than there is in the United States.

However, there were some consistencies in the Swedish out-patient psychiatric services I observed that are at least indicative of a broad national approach to what I will call "social psychotherapy." Vail (1968) observed, when discussing Swedish social medicine, that the Swedish concept of disease is formulated more in terms of consequences than causes, i.e., perhaps of a product of numerous intrapsychic or extrapsychic forces but viewed in terms of the social consequences of the disease.

Swedish "Social Psychotherapy" therefore emphasizes the understanding and relief of the social consequences of psychiatric disorders as the most essential component of their treatment model. This impacts out-patient services in that the Swedish out-patient clinician, be it a social worker, nurse or psychiatrist, is sensitive to the social trauma of the client and regards the relief of this trauma as within the scope of out-patient management. Where indicated the out-patient clinician makes many collateral contacts on behalf of the client and does not seek medication and/or the manipulation of interpsychic forces as the major

solution to the consequences of the psychiatric problems of the patient.

As we shall see, the tendency to use an out-patient team of a psychiatrist and social worker observable in the Northeast Psychiatric District, and the later discussion roles of each, may underscore this observation.

Residential Care

Judged on the availability of residential care facilities for psychiatric patients within the Northeast Psychiatric District and my own interviews and observations there seems to exist a recognition that there are many patients unable to manage independent living after psychiatric hospitalization and who require supervised group living arrangements. There are two schemes to provide this care, the "home" and the "familjevard."

The home is typically a large house or remodeled publicly owned building which has living facilities for anywhere from typically 12 to 25 patients. There is supervision by nurses, casework services by a consulting social worker and psychiatric supervision of staff and regular visitation to patients. There are larger "homes" of 100 patients or more but the typical is 12 to 25. Although patients are encouraged to progress to independent living there are provisions for those patients who are simply too disabled to function outside of supervised care.

The "familjevard" refers to private individuals and organizations which contract to provide "family living" to chronic psychiatric patients.

CHAPTER III

EXAMINATION OF THE NORTHEAST ADMINISTRATIVE DISTRICT: STOCKHOLM LANS

The following is a description of the Northeast Psychiatric District translated from a manual furnished by the Health and Medical Services Committee of the Stockholm County Council. The intent in using this description is to explain the administrative structure and services of the Swedish Psychiatric District concept as it was reorganized in 1967. Although a much more extensive study of Sweden's mental health system is needed to determine how typical the services, it is typical in organizational structure, includes the battery of mental health services that make up the essential components of the Swedish model.

SERVICE AREA

Catchment Population and Admissions

The Northeast Administrative District contains the following municipalities and population. The population of greater Stockholm is estimated to be around 800,000 and the municipalities contained within the Northeast District account for approximately one half of that population.

Danderyd	27,750
Haninge	29,576
Lidingo	35,302
Norrtalje	38,701
Nynshann	18,626

Sollentuna	10,377
Solna	5,877
Stockholm residential district	57,038
Tiyresa	28,743
Toby	38,412
Vallentuna	13,863
Vanholm	23,503
East Sodertalje	<u>77,622</u>
Total	425,392

In the fifteen year period from 1958 to 1973 there were 5,364 admissions for mental disorders reported or 1.48 percent of the population within the district. Of those admitted 4,026 were admitted to the adult psychiatric clinic at Doneryds and almost 75 percent of those were acute commitments. In 1973 the total number of hospital care days were 226,012 and total physician-psychiatrist psychiatric contacts were 27,848 or 5.4 visits per 100,000 population. No figures in terms of average length of hospitalization or diagnostic category were available.

ORGANIZATIONAL STRUCTURE

Under the Stockholm County Council is the Health and Medical Services Committee, which has thirteen members representing the four dominant political parties and is supported by a staff of thirteen consultants, secretaries and assistants. It is the function of this committee to give local implementation to the national health program and give feedback to national planners, (refer to Figure 2, page 18). These committee consultants include medical care planners, fiscal managers, personnel experts and building experts.

Under this committee is the superintendent for medical care (and assistant) whose chief responsibility is to implement and give overall administration to the district.

Within Stockholm county there are five districts under the direction of the Council Committee on Health and Medical Services and from this point five similar structures along the lines of the Northeast District. (Figure 3, page 34).

As the section we are interested in is psychiatry (Figure 4, page 35) represents the organization within the psychiatric section (Psychiatriblocket).

The administrative area is the same size as a medium sized county council in the provinces other than Stockholm. As can be seen by the chart the medical care is organized by departments or blocks, each of which has a director or chief who in most ways is the equivalent of a hospital administrator. His responsibilities are limited to one area of medicine and are responsibilities in terms of services rather than a particular facility. The term "vertical" hospital was used to describe this organizational concept which consists of various facilities offering various services but all under one central administration.

In order that hospitals receive some amount of community liaison a member of the local government is assigned to each facility within the municipality it resides. For example, Norrtaljehemmet, a long-term care facility for female psychiatric patients has a person assigned to it from the municipality of Norrtalje. For the 18 facilities contained

Ministry of Social Affairs

National Board of Health

Other Regional Admin. Districts Stockholm Gatesborg Malmo
Lans

Health and Medical Care Committee Consultants

Superintendent for Medical Care

Northeast District Hospital Superintendent

Chief Administrator Chief Physician

Opera- tions	Mainten- ance	Finance	Personnel	Medicine	Surgery	Longterm Care	Psychiatry	Ancillary Services
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Figure 3. Organization chart of health and medical services for Stockholm Lons.

Source: Psykiatriblocket: Nord Ostra Forvaltrings Omradet, 1974, Stockholm City Council.

District Manager -- Chief Physician

District Administrative Staff
 District Secretary
 Chief Supervisor
 Chief of Social Work
 Chief of Psychotherapy
 Chief of Psychology

<u>Child and Adolescent</u>	<u>Longterm Care/Rehab</u>	<u>Social Psychiatric Clinics*</u>	<u>Adult In-patient</u>
Donderyds Hospital Heimdalsgarden	Blylehemmet Norrbyhemmet Vaxhomshemmet Hock homsundhemmet Knivstahemmet Norrtalehemmet Rimbohemmet Heimdalsgarden	Donderyds Hospital Hallstauilt Hander Nynashamn Toby Lidingo Norrtalehemmet	Donderyds Hospital

* Out-patient Psychiatric Clinics

Figure 4. Organization of Northeast District Psychiatric block.

Source: Psykiatriblocket: Nord Ostra Forvaltrings Omradet, 1974, Stockholm City Council.

within the district there are twenty-one such liaison persons. Because of its size Donderyds is assigned three.

MANAGEMENT SCHEME

Management for psychiatric care within the district rests with the district manager and chief district physician. Besides direct management, planning and coordination activities, the management team is responsible for all resource allocation and utilization relevant to psychiatric care within the district. Planning is the overall emphasis at this level.

The administrative staff (see Figure 4, page 35) handles the actual day to day administrative workload plus need assessment activities, information systems management, personnel administration and planning input management.

As the reader will notice, the district administrative staff is organized by professional role, which is consistent with the concept of the district as a multi-service, multi-facility hospital. The district supervisor is responsible for patient care personnel and patient care management, just as the chief social worker is responsible for social work personnel and activities within the district and so on with the physiotherapy and psychology sectors. All these individuals coordinate their activities and the activities of their departments with the district secretary.

The bottom management level is at the facilities themselves, each of which has an administrative chief. However,

the administrative chief is mainly responsible to coordinate activities within his facility and manage the support personnel (clerks, secretaries, housekeepers) necessary to keep the facility functioning.

Ancillary Management Groups

Within the district there are three different groups having management input; the Administrative District Activities Committee which is made up of employer and employees within the area and is for the purpose of dealing with labor questions (the term "question" rather than dispute was used though the committee does arbitrate conflicts); the "works" council which is an advisory committee made up of representatives from unions and political parties within the district; and a committee made up of representatives from the various consultants to the district.

Facility Descriptions

Donderyds Adult Psychiatric In-patient Clinic

The clinic has a 200 bed capacity located within the Donderyds Hospital complex which is Sweden's largest, best equipped, and most modern hospital. Donderyds Hospital is the nation's teaching center as well, so the psychiatric services at Donderyds has interns, and residents from pharmacy, nursing, social work and medicine in addition to the regular staff. Within the clinic there are five general "long-term" care wards (three weeks average stay) which are

"open" nurse-care wards, two closed emergency reception wards, a day treatment ward of 22 patients, an acute in-patient ward (generally less than one week length of stay), an alcohol ward, narcotics ward, a children's ward, and an emergency out-patient reception area. The wards have between 18 and 25 patients. Each ward is generally assigned a social worker, physiotherapist, one Registered Nurse, and three-four practical nurses. The clinic has 15 physicians, (excluding the chief physician) who are responsible for in-patient care and out-patient services within the district.

Social Psychiatric Clinic, Donderyds

This clinic serves northern Stockholm residential districts and is staffed by seven social workers, three full-time physicians and one assistant psychologist besides the administrative staff. With the in-patient clinic and social club (described below) it shares a large physiotherapy/recreation area within the Donderyds complex which includes a woodworking, pottery, and weaving facilities.

"I Samma Bat" Social Club

Located in Donderyds Hospital Complex is the headquarters of a club for psychiatric patients, with no requirements for participation. The club has ownership of athletic and camping equipment, books, magazines, painting, weaving, pottery and leathercraft equipment furnished from the Northeast Administrative District Budget. Although the club has one paid staff member and assistant, they work chiefly as coordinators and the club members plan their own activities.

The title of the club translates to "In the Same Boat" referring to its emphasis as a self help social club. The only role professionals take is in referring people to the club, "ISB" club members regularly visit hospitalized patients in recruiting activities. While I was visiting there was an effort to relocate the club headquarters to a house a few blocks from Doneryds Hospital because members felt that its location in the hospital connoted illness and dependency rather than health and self-responsibility.

Social Psychiatric Clinics

Like the Donderyds Social Psychiatric Clinic these clinics serving psychiatric out-patients are staffed primarily by a physician and social worker. With the exception of the largest clinic located within the Donderyds Hospital Complex these clinics have psychiatrists from among the sixteen having staff responsibilities at the Donderyds in-patient facility. Depending upon the size of the clinic the social worker staff may or may not have responsibilities at Donderyds Hospital. The following are the list of clinics within the district and their respective staffings.

Hollstovick: One psychiatrist two days per week and a half-time social worker.

Norrtalje: One psychiatrist, one social worker, and one Registered Psychiatric Nurse one day per week.

Handen: One physician, one social worker, one nurse.

Mjmashomn: One physician, one social worker, one nurse.

Toby: One physician, one social worker.

Lodsingo: One psychiatrist.

Long-term Care/Rehabilitation Facilities

Bylehemmet. A sixteen bed long-term rehabilitation facility for female chronic psychiatric patients able to care for themselves with supervision. Although the length of stay is open the emphasis is upon self-sufficiency and/or return to family care. Besides a psychiatric nurse on duty the facility has a social worker and psychiatrist one day per week.

Norrlyhemmet. A 124 bed facility located on a dairy farm bordering a lake which has besides general psychiatric patients a ward each for adolescents, narcotics, and recovering alcoholics. There is a restricted length of stay to a 90 day treatment plan decided upon by a committee of staff members with an emphasis on self-sufficiency and independency. Vocational training is emphasized in the areas of weaving, furniture renovation, farming and carpentry. It is staffed primarily by psychiatric nurses, vocational training guides but has one full-time social worker. A psychiatrist consults one day per week.

Vaxholmhemmet. A 22 bed facility which provides rehabilitation care for general psychiatric patients similar to that of Bylehemmet. It has social work and psychiatric consultation one day per week.

Husby Hemmet. A fourteen bed facility providing long-term rehabilitation for alcoholics discharged from the recovery program at Doneryds. This facility shares staff with the alcohol recovery ward at Doneryds.

Hockholmsundshemmet. This is also a fourteen bed alcohol recovery facility like that located at Husby.

Knivstahemmet. This 127 bed facility has long-term care services for patients having chronic psychiatric disorders that are less likely to be able to manage outside institutional care, including those having organic brain disorders. Although there is one day per week psychiatric and social work consultation.

Norrfaljemmet. A 49 bed facility for female chronic psychiatric patients, primarily elderly requiring lesser restrictive institutional care. Like Knivstahemmet it includes many organic disorders. There are two days per week of social work consultation and one day of psychiatric.

Rimbohemmet. A ten bed facility which is designed for surrogate family living rehabilitation. The patients are general psychiatric who are essentially able to care for themselves with minimal supervision.

Family Living Arrangements (Familjevarde)

There is a system similar to adult foster care whereby families contract with the Stockholm County Council to take in psychiatric patients. The patients are usually placed in groups, according to 1974 statistics there were 115 patients in 20 private homes.

This practice is similar to the adult foster care system in the United States in that individuals are paid a remuneration by the state to provide care and supervision for adults having severe mental impairment. In Sweden this is regarded as an innovation of the past few years.

Services for Children

The district has a child and adolescent clinic located in a single story building within the Donderyds complex. There are two eleven bed wards, one secure and one nonsecure. Patients are between the ages of six and eighteen and are generally adolescents. The emphasis of this clinic is on diagnosis. It is comparatively heavily staffed with six psychiatrists, five psychologists, five social workers and two teachers.

In addition, there is a ten bed long-term care facility located at Heimdolsgarden which is restricted to adolescents with general psychiatric disorders not of organic cause, major brain trauma, or mental retardation.

Out-patient social psychiatric clinics also serve children, although none appear to specialize in children's services.

GENERAL OBSERVATIONS

Organizational Scheme

It can be concluded from the organizational charts (Figures 3 and 4) the administration of psychiatric services is highly centralized and integrated with the national

health care system. As I stated earlier, the Swedish literature described this centralized organizational concept as a "vertical hospital," meaning that the various facilities offering various services are under a central administration and comprise a macro-hospital. The Northeast District Hospital's "Psykiatrikblock" (Psychiatric Department) is but one of five departments within the macro-hospital despite the fact that it has administrative responsibility for various facilities and personnel.

The planning and service implications of this type of organizational scheme are many, but I will confine my observations to those most relevant to psychiatric services.

The first of these observations is that this scheme promotes the comprehensive planning process so much emphasized in Sweden's domestic policies. Although mental health professionals are viewed as important information sources in the planning process, their chief responsibilities are to implement and disseminate services rather than to plan them. This process is a rigid one and although there are comparably abundant resources allocated to psychiatric services, it is difficult to deviate from the planned services despite changes in need. For example, it was not readily possible to acquire two more sheep for the Norrbyhemmet rehabilitation farm despite the great interest shown by patients in their husbandry. There was no excess \$50.00 to buy two sheep without resorting to a lengthy bureaucratic process

because the need for these animals had not been spoken to in the previous year's planning. Two frustrations voiced by mental health professionals were this rigidity of program and lack of direct input.

Another observation in terms of the planning process is that neither the consumer nor the clinician is "in the driver's seat" in terms of planning control. The "planners" are a thirteen member committee representing the four principal political parties which make decisions based upon a staff of expert consultants who represent management and health care professions. This committee itself is bound by central budget and policy decisions made by the national government. This planning process, while impeding service duplication and frivolous expenditures has negative consequences in terms of impeding innovation on the part of clinicians.

Another observation apparent about this centralized scheme of health care organization is that it reflects a balance between institutional care and community based care for the mentally ill. My observations and involvement in a professional capacity in the Washington State mental health system leaves me with the conclusion that community mental health services and the state mental institutions operate more as different systems in competition and conflict with one another than a single integrated system. Between the clinicians at the Washington State Hospital and the community there exists little in the way of cooperative efforts.

In the Swedish model, however, there is no organizational staff, clinicians serving out-patients and the Donderyds' in-patients are frequently shared and there is no independent planning between out-patient and in-patient systems. In concrete terms, this staffing system allows a smoother transition from hospital to community for the patient.

A final observation relevant to the organizational scheme is that each of the facilities, apart from its responsibility to a central administration is assigned community liaison person whose function it is to ensure productive relationships between the facility and the community. This is an important acknowledgement of the importance of community attitudes that is not universal.

Rehabilitation Programs

My direct observations included a site visit and staff interviews at two rehabilitation programs for those having severe psychiatric disabilities, the I.S.B. social club and the Norrbyhemmet rehabilitation farm. I picked them out for comment because they represent two central concepts in the Swedish approach to treatment.

The I.S.B. ("In the Same Boat") social club was located in the ground level Donderyds Hospital complex. There were no formal membership requirements, though members were usually referred prior to discharge from in-patient psychiatric care. Club facilities included recreational items such as camping and hiking gear, game tables, books and day

lounge. The club staff included a recreation coordinator and an assistant, but no psychiatric clinicians. Club members have access to all recreational facilities used by inpatients and were allowed to plan occasional trips at government expense (including to the Canary Islands, a popular resort spot for Swedes). The emphasis of the club was to provide an alternative to loneliness and isolation other than hospitalization and some amount of structure and diversion from psychiatric symptoms which are congruent with the "day treatment" component of the United States approach. A chief difference is that participants are members not patients. There is an emphasis upon member control of the club and its activities and there is no person dispensing "treatment." Yet it is regarded as a program because it is a government sponsored effort to relieve the consequences of psychiatric disability.

An example of residential treatment, Norrbyhemmet, is a farm located approximately 60 miles north of Donderyds having 124 patients. The farm has various forms of vocational work training activities including furniture building and repair, carpentry, weaving, and animal husbandry. Patients are referred from within the Northeast District primarily. They occasionally accept patients from other districts throughout Sweden dependent upon vacancy and circumstances. Patients are accepted for a period of 90 days, although there are exceptions to this fairly often when a pa-

tient requires a longer period. There are specific programs for narcotic abusers, alcohol abusers and adolescents as well as general psychiatric patients. The staff includes vocational training guides, psychiatric nurses, and a full-time social worker. Each patient is assigned to a ward whose nurse takes responsibility for counseling and support, and has an individualized program agreed upon by the patient and staff planning committee. The goals vary with each patient, the overall being to foster the ability to manage at that person's optimal level of social functioning. In fact, many patients are expected to seek employment upon leaving Norrbyhemmet.

This program was noteworthy in that it acknowledged that rehabilitation potential in people with severe psychiatric problems allowed a more gradual transition from the "sick role" to self-sufficiency. This acknowledgement is an example of Vail's (1968) observation that illness in Sweden is viewed in terms of social consequences in preference to concentration of causal factors.

PROFESSIONAL TRAINING AND FUNCTIONS

In the Northeast Psychiatric District there were four classifications of mental health professionals represented in out-patient, in-patient, and residential treatment facilities. They were similar in title to counterparts in the United States and tended to share the same major functions. I will describe these four types of mental health profes-

sionals in turn and briefly compare them to their counterparts in the United States in terms of training, professional function, and relationship within the professional hierarchy.

Lakare (Overlakare, Underlakare)

This title simply refers to a physician. In the Swedish context one is referred to as a physician whether or not one's area of expertise is psychiatry, surgery or internal medicine. Excepting residents and interns the "Likare" in the Northeast Psychiatric District were physicians who had completed a residency in psychiatry, similar to but much shorter than the psychiatrist in the United States. In general, the Swedish physician whose practice was in psychiatry had completed after secondary school five years of academic and clinical training at a University Medical School, a six month rotating internship and a one year residency in psychiatry. The United States counterpart completes (usually) four years of undergraduate study, four years of medical school, a one year internship and three years of psychiatric residency.

In my observations of the United States there are two classifications of psychiatric patients; "private" and "assigned." The "private" patient is often a patient with private resources (income, medical insurance or family resources) who is able to stay in treatment with a particular psychiatrist on a regular basis because of the existence of these resources.

The "assigned" patient is one who sees a psychiatrist by virtue of the latter's obligation to treat the patient as a part of staff responsibilities in an out-patient or hospital setting. There is perhaps a strong tendency among psychiatric clinicians to make a favorable distinction with respect to the private patient over the "assigned" in terms of both diagnosis and treatment.

Because of the Universal Medical Insurance Plan and the resultant fact that Swedish psychiatrists have comparably few patients not under public payment, there appears to be a greater tendency to regard all patients as "private" and for the same psychiatrist to see a patient both inside and outside the hospital. In functional emphasis psychiatrists in the Northeast Psychiatric District had staff duties both at the out-patient clinic and hospital and would do the daily commuting rather than the patient. It was not considered unusual for a psychiatrist to take a patient home after a hospital stay while making clinical rounds. Although social workers were available at the hospital, residential treatment centers and out-patient clinics, psychiatrists frequently do collateral contacts on behalf of "their" patients to relatives, employers, and agencies much like a caseworker in the United States. This perhaps is another example of the Swedish concept of illness as a social consequence that must be treated accordingly.

Psykolog

The psykolog is the equivalent of the psychologist in the United States, both in training and function. The psykolog training requirements involve five to six years of clinical and academic training at a University. In function they are utilized primarily for testing, measurement, and evaluation.

Until recently the utilization of psykologs has been limited to testing and evaluation and not so much as vendors of psychotherapy. For example, psykologs in the Northeast Psychiatric District (only five in number as compared to 30 social workers) are not represented on the staff of the out-patient clinics. However, I have been informed by the administrator of Norrbyhemmet that psykologs are becoming more aggressive about involving themselves as vendors of psychotherapy, a move that is regarded with some reservation and skepticism by physicians in psychiatric practice. This conflict has a long history in the United States.

Kurator

The Swedish social worker (Kurator) is well represented in number and function in the Northeast Psychiatric District. In training they undergo three years of academic and clinical training at a university school of social work. Unlike in the United States, there is no bachelors degree requirement.

The function of the social worker is less dependent on clinical setting than in the United States, their role essentially involves what could succinctly be described as supporting and enabling the patient to achieve an optimal level of functioning through contact with the patient and his or her significant community. Like the Swedish psychiatrist kurators in the Northeast Psychiatric District had dual responsibilities at out-patient clinics, residential treatment facilities and the hospital. Unlike the psychiatrist and the United States counterpart the Swedish social worker did not appear to engage in activities we refer to as psychotherapy; e.g., exploring, assessing, and resolving the causal factors of a patient's dysfunction through an intensive therapeutic relationship. The social workers I talked with at Donderyds Hospital were surprised that in the United States this activity was very much within the scope of social work practice.

A second observation worthy of note was what appeared to be the existence of cordial and personal relations between the kurator and lokare in the face of the professional hierarchy.

Although it at first appeared that a professional hierarchy did not exist except in terms of function, I later became aware through interviews that, although the hierarchy was very much in existence both in terms of status and professional function, it was rarely challenged and thus is not

the source of tension that it is in the United States. Stated one Swedish psychiatrist I had conversed with on this matter, "We (social worker and psychiatrist) are both doing our job and it is good to be friends." This attitude may not be general, but it appeared to be pervasive in the Northeast Psychiatric District.

Sjukskolterska

In Sweden the Sjukskolterska is equivalent to the Registered Nurse both in training and function. There is, however, a formal six month residency training in the nurses' area of specialization as a requirement of licensure. The psychiatric nurse is trained to practice both in out-patient and hospital settings. As in the United States, it is the psychiatric nurse's chief responsibility to implement treatment under a physician's supervision and direction and take primary responsibility for the patient's treatment and care while hospitalized. Because of this, the psychiatric nurses appeared to develop and maintain more intense therapeutic relationships with patients than the social work staff both in hospitals and residential treatment facilities. The residential treatment facilities were staffed primarily by psychiatric nurses with psychiatric and social work consultation, which also would seem to have an intensifying effect on the psychiatric nurse -- patient relationship.

Other Psychiatric Treatment Personnel

There are three other classifications of psychiatric personnel which have direct involvement in the psychiatric

treatment of patients within the Northeast Psychiatric District. These personnel are assigned to the in-patient and residential treatment facilities. They are as follows: the skoltore, equivalent to the Licensed Practical Nurse; the arbetsterapeut, or occupational trainer; and the physiotherapist. While the skotare, a Licensed Practical Nurse is a common enough feature in American hospitals and the occupational trainer is essentially an occupational therapist, the Swedish physiotherapist is a person trained in physical recreation assigned to the task of involving patients in those group athletic activities. Like good nutrition, physical recreation is considered an important component of the patient's treatment plan.

USE OF MEDICATION

My observations and interviews were not adequate to assess the classifications and extent of psychotropic medication use, though many of the same generic classifications of major and minor tranquilizers, anti-psychotics and anti-depressant medications were evident. A comparison of routine hospital admission orders for alcoholics and combative patients showed no essential differences between those at the Donderyds Psychiatric service and three hospitals in Washington state I am familiar with. There were problems referred to about the tendency to overprescribe and abuse such minor tranquilizers as Librium and Valium which is certainly a dilemma in the United States.

CHAPTER IV

IMPLICATIONS FOR SOCIAL WORK PRACTICE IN THE UNITED STATES

It is easy to make the basic error of idealizing a system or technology when one lacks sufficient familiarity and knowledge of that system to see the basic flaws. Awareness of the flaws within our own system of doing things leaves a tendency to idealize whatever is new, foreign or different. Although I tried to avoid this tendency when evaluating Swedish psychiatric services there is one theme within that system which I accepted with uncritical admiration, a theme which is basic to the Swedish concept of disease.

Vail (1968) described the Swedish concept of disease as something that occurs to a person which is recognized more in terms of consequences than causal factors. The consequences of psychiatric disorders, independent of diagnostic label often include unemployment, disruption of family and community ties, isolation, loss of independent living skills and essentially a disruption or loss of a person's ability to control his life. Menninger (1963) approached this concept of disease when he described psychiatric disorders in terms of levels of dysfunction. The task of the psychiatric system according to the model that

recognizes disease in terms of consequences is the management of a social response that is geared to the specific needs of the person which themselves represent the disease consequences.

The impressive social response observed through the services of the Northeast Psychiatric District included provision of rehabilitation and supervised community living for people with psychiatric disabilities. The Northeast Psychiatric District, with a population of approximately 400,000 or one-sixteenth of the nation's population, had eight facilities (excluding hospitals and out-patient psychiatric clinics) providing long-term residential rehabilitation. Besides offering a direct alternative to the revolving hospital door these facilities have programs which focus upon optimal functioning rather than custodial care. According to my observation and interviews the word chronic (obotlig) was avoided because of its implications in terms of consequences, i.e., that one cannot be rehabilitated. Goran Hargerfelth, Administrator of Norrbyhemmet rehabilitation farm, while touring a Pennsylvania state hospital in February 1979 became dismayed at what he perceived as the rather free use of the word "chronic." "It is out there for the patients to see it, surely many of them should get better." This reluctance among Swedish mental health professionals to state or imply that a person is chronically ill may account for the relative infrequency of diagnosis

within the psychotic classifications observed by Vail (1968). Perhaps the Swedish mental health professionals have discovered, like Matza (1968), Schur (1971) and Wing and Brown (1970) that terms like chronic have some self-fulfilling properties.

In America there is an opinion that the psychiatric system has fallen short of responding directly to the consequences of mental illness. Stuart and Therrien (1975) assert that the common thrust of all our mental health programs are based upon a belief system that does not take into account the real problems of those patients with long range needs as evidenced by their analysis of public documents, recent publications, and interviews with community mental health centers staff. Benson's (1977) analysis of the California state policy indicated a lack of theoretical attention to the primary deviation of mental illness and its consequences which negatively effects policies and programs. Kirk and Greenly (1974) and Kellert (1971) express concern that existing community rehabilitation services are not geared to give access to the seriously mentally ill, and Trotter and Kuttner (1974) point out that the rhetoric about the community mental health movement has not improved the quality of life for many of the seriously mentally ill above that found in the "back wards" of state hospitals.

Just speaking from my own experience as a community mental health specialist in Washington state there has been a notable decline rather than an increase in the number of

residential treatment facilities providing hospital to community transition for adult psychiatric patients during the last five years despite an official policy encouraging community resources (Revised Code of Washington, Chapter 71.05, 1974). Because these rehabilitation facilities do not fit within Federal funding guidelines and for adequate Medicare and Medicaid reimbursement they have been allowed to fold while community mental health center programs remain limited in their ability to provide the needed services for the seriously mentally ill. The H.E.W. Planning and Research Division for Region Ten support this view in their "Evaluation of the Deinstitutionalization Process in H.E.W. Region Ten" report released in February, 1978.

With these shortcomings of current mental health program strategies in mind, we in the social work profession might face the fact that services dealing directly with the consequences of serious mental illness should be given consideration and are worthy of research.

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